General Assembly **Substitute Bill No. 1249**

January Session, 2005 *____SB01249FIN__050305___*

AN ACT CONCERNING PREFERRED PROVIDER NETWORKS.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 38a-479aa of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2005*):

(a) As used in this part and subsection (b) of section 20-138b:

(1) "Covered benefits" means health care services to which an enrollee is entitled under the terms of a managed care plan;

(2) "Enrollee" means an individual who is eligible to receive health care services through a preferred provider network;

(3) "Health care services" means health care related services or products rendered or sold by a provider within the scope of the provider's license or legal authorization, and includes hospital, medical, surgical, dental, vision and pharmaceutical services or products;

(4) "Managed care organization" means (A) a managed care organization, as defined in section 38a-478, (B) any other health insurer, or (C) a reinsurer with respect to health insurance;

(5) "Managed care plan" means a managed care plan, as defined in section 38a-478;

(6) "Person" means an individual, agency, political subdivision, partnership, corporation, limited liability company, association or any other entity;

(7) "Preferred provider network" means **[**a person, which is not a managed care organization, but which pays claims for the delivery of health care services, accepts financial risk for the delivery of health care services and establishes, operates or maintains an arrangement or contract with providers relating to (A) the health care services rendered by the providers, and (B) the amounts to be paid to the providers for such services**]** a person who establishes, operates, maintains or is financially responsible for, in whole or in part, an arrangement in which an agreement relating to the health care services to be rendered by providers is entered into between such providers and the person, and includes any provider-sponsored arrangement or independent practice association that offers network services. "Preferred provider network" also includes a risk-bearing preferred provider network. "Preferred provider network" does not include a workers' compensation preferred provider organization established pursuant to section 31-279-10 of the regulations of Connecticut state agencies; or an independent practice association or physician hospital organization whose primary function is to contract with insurers and provide services to providers;

(8) "Provider" means an individual or entity duly licensed or legally authorized to provide health care services; **[**and**]**

(9) "Commissioner" means the Insurance Commissioner; and

(10) "Risk-bearing preferred provider network" means a person, which is not a managed care organization, but which (A) establishes, operates or maintains an arrangement or contract with providers relating to (i) the health care services rendered by providers, and (ii) the amounts to be paid to the providers for such services, and (B) uses the funds of a licensed insurer or other third party to pay providers.

[(b) On and after May 1, 2004, no preferred provider network may enter into or renew a contractual relationship with a managed care organization unless the preferred provider network is licensed by the commissioner. On and after May 1, 2005, no preferred provider network may conduct business in this state unless it is licensed by the commissioner. Any person seeking to obtain or renew a license shall submit an application to the commissioner, on such form as the commissioner may prescribe, and shall include the filing described in this subsection, except that a person seeking to renew a license may submit only the information necessary to update its previous filing. Applications shall be submitted by March first of each year in order to qualify for the May first license issue or renewal date.**]**

(b) Any preferred provider network that seeks to conduct business in this state shall, prior to accepting enrollees, file the information required in this subsection with the commissioner. Before each May first thereafter, each preferred provider network that continues to do business in this state and that has completed an initial filing shall file with the commissioner the information necessary to update its previous filing. The filing required from such preferred provider network shall include the following information: (1) The identity of the preferred provider network and any company or organization controlling the operation of the preferred provider network, including the name, business address, contact person, a description of the controlling company or organization and, where applicable, the following: (A) A certificate from the Secretary of the State regarding the preferred provider network's and the controlling company's or organization's good standing to do business in the state; (B) a copy of the preferred provider network's and the controlling company's or organization's financial statement completed in accordance with sections 38a-53 and 38a-54, as applicable, for the end of its most recently concluded fiscal year, along with the name and address of any public accounting firm or internal accountant which prepared or assisted in the preparation of such financial statement; (C) a list of the names, official positions and occupations of members of the preferred

provider network's and the controlling company's or organization's board of directors or other policy-making body and of those executive officers who are responsible for the preferred provider network's and controlling company's or organization's activities with respect to the health care services network; (D) a list of the preferred provider network's and the controlling company's or organization's principal owners; (E) in the case of an out-of-state preferred provider network, controlling company or organization, a certificate that such preferred provider network, company or organization is in good standing in its state of organization; (F) in the case of a Connecticut or out-of-state preferred provider network, controlling company or organization, a report of the details of any suspension, sanction or other disciplinary action relating to such preferred provider network, or controlling company or organization in this state or in any other state; and (G) the identity, address and current relationship of any related or predecessor controlling company or organization. For purposes of this subparagraph, "related" means that a substantial number of the board or policy-making body members, executive officers or principal owners of both companies are the same; (2) a general description of the preferred provider network and participation in the preferred provider network, including: (A) The geographical service area of and the names of the hospitals included in the preferred provider network; (B) the primary care physicians, the specialty physicians, any other contracting providers and the number and percentage of each group's capacity to accept new patients; (C) a list of all entities on whose behalf the preferred provider network has contracts or agreements to provide health care services; (D) a table listing all major categories of health care services provided by the preferred provider network; (E) an approximate number of total enrollees served in all of the preferred provider network's contracts or agreements; (F) a list of subcontractors of the preferred provider network, not including individual participating providers, that assume financial risk from the preferred provider network and to what extent each subcontractor assumes financial risk; and (G) **[**a contingency plan describing how contracted health care services will be provided in the event of insolvency; and

(H)**]** any other information requested by the commissioner; and (3) the name and address of the person to whom applications may be made for participation.

(c) Any person developing a preferred provider network, or expanding a preferred provider network into a new county, pursuant to this section and subsection (b) of section 20-138b, shall publish a notice, in at least one newspaper having a substantial circulation in the service area in which the preferred provider network operates or will operate, indicating such planned development or expansion. Such notice shall include the medical specialties included in the preferred provider network, the name and address of the person to whom applications may be made for participation and a time frame for making application. The preferred provider network shall provide the applicant with written acknowledgment of receipt of the application. Each complete application shall be considered by the preferred provider network in a timely manner.

(d) (1) Each preferred provider network shall file with the commissioner and make available upon request from a provider the general criteria for its selection or termination of providers. Disclosure shall not be required of criteria deemed by the preferred provider network to be of a proprietary or competitive nature that would hurt the preferred provider network's ability to compete or to manage health care services. For purposes of this section, criteria is of a proprietary or competitive nature if it has the tendency to cause providers to alter their practice pattern in a manner that would circumvent efforts to contain health care costs and criteria is of a proprietary nature if revealing the criteria would cause the preferred provider network's competitors to obtain valuable business information.

(2) If a preferred provider network uses criteria that have not been filed pursuant to subdivision (1) of this subsection to judge the quality and cost-effectiveness of a provider's practice under any specific program within the preferred provider network, the preferred

provider network may not reject or terminate the provider participating in that program based upon such criteria until the provider has been informed of the criteria that the provider's practice fails to meet.

(e) Each preferred provider network shall permit the Insurance Commissioner to inspect its books and records.

(f) Each preferred provider network shall permit the commissioner to examine, under oath, any officer or agent of the preferred provider network or controlling company or organization with respect to the use of the funds of the preferred provider network, company or organization, and compliance with (1) the provisions of this part, and (2) the terms and conditions of its contracts to provide health care services.

(g) Each preferred provider network shall file with the commissioner a notice of any material modification of any matter or document furnished pursuant to this part, and shall include such supporting documents as are necessary to explain the modification.

[(h) Each preferred provider network shall maintain a minimum net worth of either (1) the greater of (A) two hundred fifty thousand dollars, or (B) an amount equal to eight per cent of its annual expenditures as reported on its most recent financial statement completed and filed with the commissioner in accordance with sections 38a-53 and 38a-54, as applicable, or (2) another amount determined by the commissioner.**]**

(h) No risk-bearing preferred provider network may conduct business in this state unless it is licensed by the commissioner in accordance with this section. Any person seeking to obtain or renew a license as a risk-bearing preferred provider network shall submit an application to the commissioner, on such form as the commissioner may prescribe and shall include the filing described in subsection (a) of this section and the filing fee set forth in section 38a-11, as amended by this act, except that a person seeking to renew a license may submit

only the information necessary to update its previous filing. Applications shall be submitted by March first of each year in order to qualify for the May first license issue or renewal date.

(i) Each risk-bearing preferred provider network shall maintain or arrange for a letter of credit, bond, surety, reinsurance, reserve or other financial security acceptable to the commissioner for the exclusive use of paying any outstanding amounts owed participating providers in the event of insolvency or nonpayment except that any remaining security may be used for the purpose of reimbursing managed care organizations in accordance with subsection (b) of section 38a-479bb, as amended by this act. Such outstanding amount shall be at least an amount equal to the greater of (1) an amount calculated on the basis of the sum of two quarters within the past year with the greatest amounts owed by the risk-bearing preferred provider network to participating providers, (2) the actual outstanding amount owed by the risk-bearing preferred provider network to participating providers, or (3) another amount determined by the commissioner. **[**Such amount may be credited against the preferred provider network's minimum net worth requirements set forth in subsection (h) of this section.**]** The commissioner shall review such security amount and calculation on a quarterly basis.

(j) Each risk-bearing preferred provider network shall pay the applicable license or renewal fee specified in section 38a-11, as amended by this act. The commissioner shall use the amount of such fees solely for the purpose of regulating preferred provider networks.

(k) In no event, including, but not limited to, nonpayment by the managed care organization, insolvency of the managed care organization, or breach of contract between the managed care organization and the preferred provider network, shall a preferred provider network bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against an enrollee or an enrollee's designee, other than the managed care organization, for covered benefits provided, except that

the preferred provider network may collect any copayments, deductibles or other out-of-pocket expenses that the enrollee is required to pay pursuant to the managed care plan.

(l) Each contract or agreement between a preferred provider network and a participating provider shall contain a provision that if the preferred provider network fails to pay for health care services as set forth in the contract, the enrollee shall not be liable to the participating provider for any sums owed by the preferred provider network or any sums owed by the managed care organization because of nonpayment by the managed care organization, insolvency of the managed care organization or breach of contract between the managed care organization and the preferred provider network.

(m) Each utilization review determination made by or on behalf of a preferred provider network shall be made in accordance with sections 38a-226 to 38a-226d, inclusive, except that any initial appeal of a determination not to certify an admission, service, procedure or extension of stay shall be conducted in accordance with subdivision (7) of subsection (a) of section 38a-226c, and any subsequent appeal shall be referred to the managed care organization on whose behalf the preferred provider network provides services. The managed care organization shall conduct the subsequent appeal in accordance with said subdivision.

(n) Each risk-bearing preferred provider network shall establish a contingency plan describing how contracted health care services will be provided in the event of insolvency.

Sec. 2. Section 38a-479bb of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2005*):

(a) On and after May 1, 2004, no managed care organization may enter into or renew a contractual relationship with a risk-bearing preferred provider network that is not licensed in accordance with section 38a-479aa, as amended by this act. On and after May 1, 2005, no managed care organization may continue or maintain a contractual

relationship with a risk-bearing preferred provider network that is not licensed in accordance with section 38a-479aa, as amended by this act.

(b) Each managed care organization that contracts with a risk-bearing preferred provider network shall (1) post and maintain or require the risk-bearing preferred provider network to post and maintain a letter of credit, bond, surety, reinsurance, reserve or other financial security acceptable to the Insurance Commissioner, in order to satisfy the risk accepted by the risk-bearing preferred provider network pursuant to the contract, in an amount calculated in accordance with subsection (i) of section 38a-479aa, as amended by this act, and (2) determine who posts and maintains the security required under subdivision (1) of this subsection. In the event of insolvency or nonpayment such security shall be used by the risk-bearing preferred provider network, or other entity designated by the commissioner, solely for the purpose of paying any outstanding amounts owed participating providers, except that any remaining security may be used for the purpose of reimbursing the managed care organization for any payments made by the managed care organization to participating providers on behalf of the risk-bearing preferred provider network.

(c) Each managed care organization that contracts with a risk-bearing preferred provider network shall provide to the risk-bearing preferred provider network at the time the contract is entered into and annually thereafter:

(1) Information, as determined by the managed care organization, regarding the amount and method of remuneration to be paid to the risk-bearing preferred provider network;

(2) Information, as determined by the managed care organization, to assist the risk-bearing preferred provider network in being informed regarding any financial risk assumed under the contract or agreement, including, but not limited to, enrollment data, primary care provider to covered person ratios, provider to covered person ratios by specialty, a table of the services that the risk-bearing preferred provider network is

responsible for, expected or projected utilization rates, and all factors used to adjust payments or risk-sharing targets;

(3) The National Associations of Insurance Commissioners annual statement for the managed care organization; and

(4) Any other information the commissioner may require.

(d) Each managed care organization shall ensure that any contract it has with a preferred provider network or risk-bearing preferred provider network, as the case may be, includes:

(1) A provision that requires the preferred provider network or the risk-bearing preferred provider network, as the case may be, to provide to the managed care organization at the time a contract is entered into, annually, and upon request of the managed care organization, (A) with respect to a risk-bearing preferred provider network, the financial statement completed in accordance with sections 38a-53 and 38a-54, as applicable, and section 38a-479aa, as amended by this act; (B) with respect to a risk-bearing preferred provider network, documentation that satisfies the managed care organization that the risk-bearing preferred provider network has sufficient ability to accept financial risk; (C) with respect to a risk-bearing preferred provider network, documentation that satisfies the managed care organization that the risk-bearing preferred provider network has appropriate management expertise and infrastructure; (D) with respect to all preferred provider networks, documentation that satisfies the managed care organization that the preferred provider network has an adequate provider network taking into account the geographic distribution of enrollees and participating providers and whether participating providers are accepting new patients; (E) with respect to all preferred provider networks, an accurate list of participating providers; and (F) with respect to all preferred provider networks, documentation that satisfies the managed care organization that the preferred provider network has the ability to ensure the delivery of health care services as set forth in the contract;

(2) A provision that requires the risk-bearing preferred provider network to provide to the managed care organization a quarterly status report that includes (A) information updating the financial statement completed in accordance with sections 38a-53 and 38a-54, as applicable, and section 38a-479aa, as amended by this act; (B) a report showing amounts paid to those providers who provide health care services on behalf of the managed care organization; (C) an estimate of payments due providers but not yet reported by providers; (D) amounts owed to providers for that quarter; and (E) the number of utilization review determinations not to certify an admission, service, procedure or extension of stay made by or on behalf of the risk-bearing preferred provider network and the outcome of such determination on appeal;

(3) A provision that requires the risk-bearing preferred provider network to provide notice to the managed care organization not later than five business days after (A) any change involving the ownership structure of the risk-bearing preferred provider network; (B) financial or operational concerns arise regarding the financial viability of the risk-bearing preferred provider network; or (C) the risk-bearing preferred provider network's loss of a license in this or any other state;

(4) A provision that if the managed care organization fails to pay for health care services as set forth in the contract, the enrollee will not be liable to the provider or risk-bearing preferred provider network for any sums owed by the managed care organization or risk-bearing preferred provider network;

(5) A provision that the risk-bearing preferred provider network shall include in all contracts between the risk-bearing preferred provider network and participating providers a provision that if the risk-bearing preferred provider network fails to pay for health care services as set forth in the contract, for any reason, the enrollee shall not be liable to the participating provider or risk-bearing preferred provider network for any sums owed by the risk-bearing preferred provider network or any sums owed by the managed care

organization because of nonpayment by the managed care organization, insolvency of the managed care organization or breach of contract between the managed care organization and the risk-bearing preferred provider network;

(6) A provision requiring the risk-bearing preferred provider network to provide information to the managed care organization, satisfactory to the managed care organization, regarding the risk-bearing preferred provider network's reserves for financial risk;

(7) A provision that (A) the risk-bearing preferred provider network or managed care organization shall post and maintain a letter of credit, bond, surety, reinsurance, reserve or other financial security acceptable to the commissioner, in order to satisfy the risk accepted by the risk-bearing preferred provider network pursuant to the contract, in an amount calculated in accordance with subsection (i) of section 38a-479aa, as amended by this act, (B) the managed care organization shall determine who posts and maintains the security required under subparagraph (A) of this subdivision, and (C) in the event of insolvency or nonpayment, such security shall be used by the risk-bearing preferred provider network, or other entity designated by the commissioner, solely for the purpose of paying any outstanding amounts owed participating providers, except that any remaining security may be used for the purpose of reimbursing the managed care organization for any payments made by the managed care organization to participating providers on behalf of the risk-bearing preferred provider network;

(8) A provision under which the managed care organization is permitted, at the discretion of the managed care organization, to pay participating providers directly and in lieu of the risk-bearing preferred provider network in the event of insolvency or mismanagement by the risk-bearing preferred provider network and that payments made pursuant to this subdivision may be made or reimbursed from the security posted pursuant to subsection (b) of this section;

(9) A provision transferring and assigning contracts between the risk-bearing preferred provider network and participating providers to the managed care organization for the provision of future services by participating providers to enrollees, at the discretion of the managed care organization, in the event the risk-bearing preferred provider network (A) becomes insolvent, (B) otherwise ceases to conduct business, as determined by the commissioner, or (C) demonstrates a pattern of nonpayment of authorized claims, as determined by the commissioner, for a period in excess of ninety days;

(10) A provision that each contract or agreement between the risk-bearing preferred provider network and participating providers shall include a provision transferring and assigning contracts between the risk-bearing preferred provider network and participating providers to the managed care organization for the provision of future health care services by participating providers to enrollees, at the discretion of the managed care organization, in the event the risk-bearing preferred provider network (A) becomes insolvent, (B) otherwise ceases to conduct business, as determined by the commissioner, or (C) demonstrates a pattern of nonpayment of authorized claims, as determined by the commissioner, for a period in excess of ninety days;

(11) A provision that the risk-bearing preferred provider network shall pay for the delivery of health care services and operate or maintain arrangements or contracts with providers in a manner consistent with the provisions of law that apply to the managed care organization's contracts with enrollees and providers; and

(12) A provision that the preferred provider network shall ensure that utilization review determinations are made in accordance with sections 38a-226 to 38a-226d, inclusive, except that any initial appeal of a determination not to certify an admission, service, procedure or extension of stay shall be made in accordance with subdivision (7) of subsection (a) of section 38a-226c. In cases where an appeal to reverse a determination not to certify is unsuccessful, the preferred provider network shall refer the case to the managed care organization which

shall conduct the subsequent appeal, if any, in accordance with said subdivision.

(e) Each managed care organization that contracts with a preferred provider network shall have adequate procedures in place to notify the commissioner that a preferred provider network has experienced an event that may threaten the preferred provider network's ability to materially perform under its contract with the managed care organization. The managed care organization shall provide such notice to the commissioner not later than five days after it discovers that the preferred provider network has experienced such an event.

(f) Each managed care organization that contracts with a risk-bearing preferred provider network shall monitor and maintain systems and controls for monitoring the financial health of the risk-bearing preferred provider networks with which it contracts.

(g) Each managed care organization that contracts with a risk-bearing preferred provider network shall provide to the commissioner, and update on an annual basis, a contingency plan, satisfactory to the commissioner, describing how health care services will be provided to enrollees if the risk-bearing preferred provider network becomes insolvent or is mismanaged. The contingency plan shall include a description of what contractual and financial steps have been taken to ensure continuity of care to enrollees if the risk-bearing preferred provider network becomes insolvent or is mismanaged.

(h) Notwithstanding any agreement to the contrary, each managed care organization shall retain full responsibility to its enrollees for providing coverage for health care services pursuant to any applicable managed care plan and any applicable state or federal law. Each managed care organization shall exercise due diligence in its selection and oversight of a preferred provider network.

(i) Notwithstanding any agreement to the contrary, each managed care organization shall be able to demonstrate to the satisfaction of the commissioner that the managed care organization can fulfill its

nontransferable obligations to provide coverage for the provision of health care services to enrollees in the event of the failure, for any reason, of a preferred provider network.

(j) Each managed care organization that contracts with a preferred provider network shall provide that in the event of the failure, for any reason, of a preferred provider network, the managed care organization shall provide coverage for the enrollee to continue covered treatment with the provider who treated the enrollee under the preferred provider network contract regardless of whether the provider participates in any plan operated by the managed care organization. In the event of such failure, the managed care organization shall continue coverage until the earlier of (1) the date the enrollee's treatment is completed under a treatment plan that was authorized and in effect on the date of the failure, or (2) the date the contract between the enrollee and the managed care organization terminates. **[**The**]** In the event of the failure of a risk-bearing preferred provider network, the managed care organization shall compensate a provider for such continued treatment at the rate due the provider under the provider's contract with the failed risk-bearing preferred provider network.

(k) Each managed care organization that contracts with a risk-bearing preferred provider network shall confirm the information in the quarterly status report submitted by the risk-bearing preferred provider network pursuant to subdivision (2) of subsection (d) of this section and shall submit such information to the commissioner, on such form as the commissioner prescribes, not later than ten days after receiving a request from the commissioner for such information.

(l) (1) Each managed care organization that contracts with a preferred provider network shall certify annually to the commissioner, on such form and in such manner as the commissioner prescribes, that the managed care organization has reviewed the documentation submitted by the preferred provider network pursuant to subdivision (l) of subsection (d) of this section and has determined that the

preferred provider network maintains a provider network that is adequate to ensure the delivery of health care services as set forth in the contract. If the commissioner finds that the certification was not submitted in good faith, the commissioner may deem the managed care organization to have not complied with this subsection and may take action pursuant to section 38a-479ee, as amended by this act.

(2) If the managed care organization determines that the preferred provider network's provider network is not adequate and must be increased, the managed care organization shall provide written notice of the determination to the commissioner. Such notice shall describe **[**(1)**]** (A) any plan in place for the preferred provider network to increase its provider network, and **[**(2)**]** (B) the managed care organization's contingency plan in the event the preferred provider network does not satisfactorily increase its provider network.

(m) Nothing in this part or part 1a of this chapter shall be construed to require a preferred provider network to share proprietary information with a managed care organization concerning contracts or financial arrangements with providers who are not included in that managed care organization's network, or other preferred provider networks or managed care organizations.

Sec. 3. Section 38a-479cc of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2005*):

(a) Whenever a preferred provider network is providing services pursuant to a contract with a managed care organization, the preferred provider network may not establish any terms, conditions or requirements for access, diagnosis or treatment that are different than the terms, conditions or requirements for access, diagnosis or treatment in the managed care organization's plan, except that no preferred provider network shall be required to provide an enrollee access to a provider who does not participate in the preferred provider network unless the preferred provider network is required to provide such access under its contract with the managed care organization.

(b) Whenever a risk-bearing preferred provider network is providing services pursuant to a contract with a managed care organization, the risk-bearing preferred provider network shall pay for the delivery of health care services and operate and maintain arrangements or contracts with providers in a manner consistent with the provisions of law that apply to the managed care organization's contracts with enrollees and providers.

Sec. 4. Section 38a-479dd of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2005*):

Each risk-bearing preferred provider network shall examine its outstanding amounts in each quarter and if the risk-bearing preferred provider network determines that the outstanding amounts in a quarter will exceed ninety-five per cent of the security posted pursuant to subsection (i) of section 38a-479aa, as amended by this act, the risk-bearing preferred provider network shall mail a notice to each of its participating providers concerning the status of incurred claims and shall send notice to each managed care organization with which it contracts and the Insurance Commissioner on such form as the commissioner prescribes. The commissioner shall meet with the applicable managed care organization and risk-bearing preferred provider network to ensure continued services to enrollees and payment to providers.

Sec. 5. Section 38a-479ee of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2005*):

(a) If the Insurance Commissioner determines that a risk-bearing preferred provider network or managed care organization, or both, has not complied with any applicable provision of this part, sections 38a-226 to 38a-226d, inclusive, or sections 38a-815 to 38a-819, inclusive, the commissioner may (1) order the risk-bearing preferred provider network or managed care organization, or both if both have not complied, to cease and desist all operations in violation of this part or said sections; (2) terminate or suspend the risk-bearing preferred

provider network's license; (3) institute a corrective action against the risk-bearing preferred provider network or managed care organization, or both if both have not complied; (4) order the payment of a civil penalty by the risk-bearing preferred provider network or managed care organization, or both if both have not complied, of not more than one thousand dollars for each and every act or violation; (5) order the payment of such reasonable expenses as may be necessary to compensate the commissioner in conjunction with any proceedings held to investigate or enforce violations of this part, sections 38a-226 to 38a-226d, inclusive, or sections 38a-815 to 38a-819, inclusive; and (6) use any of the commissioner's other enforcement powers to obtain compliance with this part, sections 38a-226 to 38a-226d, inclusive, or sections 38a-815 to 38a-819, inclusive. The commissioner may hold a hearing concerning any matter governed by this part, sections 38a-226 to 38a-226d, inclusive, or sections 38a-815 to 38a-819, inclusive, in accordance with section 38a-16. Subject to the same confidentiality and liability protections set forth in subsections (c) and (k) of section 38a-14, the commissioner may engage the services of attorneys, appraisers, independent actuaries, independent certified public accountants or other professionals and specialists to assist the commissioner in conducting an investigation under this section, the cost of which shall be borne by the managed care organization or risk-bearing preferred provider network, or both, that is the subject of the investigation.

(b) If a risk-bearing preferred provider network fails to comply with any applicable provision of this part, sections 38a-226 to 38a-226d, inclusive, or sections 38a-815 to 38a-819, inclusive, the commissioner may assign or require the risk-bearing preferred provider network to assign its rights and obligations under any contract with participating providers in order to ensure that covered benefits are provided.

(c) The commissioner shall receive and investigate (1) any grievance filed against a risk-bearing preferred provider network or managed care organization, or both, by an enrollee or an enrollee's designee concerning matters governed by this part, sections 38a-226 to 38a-226d, inclusive, or sections 38a-815 to 38a-819, inclusive, or (2) any referral

from the Office of Managed Care Ombudsman pursuant to section 38a-1041. The commissioner shall code, track and review such grievances and referrals. The risk-bearing preferred provider network or managed care organization, or both, shall provide the commissioner with all information necessary for the commissioner to investigate such grievances and referrals. The information collected by the commissioner pursuant to this section shall be maintained as confidential and shall not be disclosed to any person except (A) to the extent necessary to carry out the purposes of this part, sections 38a-226 to 38a-226d, inclusive, or sections 38a-815 to 38a-819, inclusive, (B) as allowed under this title, (C) to the Managed Care Ombudsman, and (D) information concerning the nature of any grievance or referral and the commissioner's final determination shall be a public record, as defined in section 1-200, provided no personal information, as defined in section 38a-975, shall be disclosed. The commissioner shall report to the Managed Care Ombudsman on the resolution of any matter referred to the commissioner by the Managed Care Ombudsman.

Sec. 6. Subsection (a) of section 38a-11 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2005*):

(a) The commissioner shall demand and receive the following fees: (1) For the annual fee for each license issued to a domestic insurance company, one hundred dollars; (2) for receiving and filing annual reports of domestic insurance companies, twenty-five dollars; (3) for filing all documents prerequisite to the issuance of a license to an insurance company, one hundred seventy-five dollars, except that the fee for such filings by any health care center, as defined in section 38a-175, shall be one thousand one hundred dollars; (4) for filing any additional paper required by law, fifteen dollars; (5) for each certificate of valuation, organization, reciprocity or compliance, twenty dollars; (6) for each certified copy of a license to a company, twenty dollars; (7) for each certified copy of a report or certificate of condition of a company to be filed in any other state, twenty dollars; (8) for amending a certificate of authority, one hundred dollars; (9) for each

license issued to a rating organization, one hundred dollars. In addition, insurance companies shall pay any fees imposed under section 12-211; (10) a filing fee of twenty-five dollars for each initial application for a license made pursuant to section 38a-769; (11) with respect to insurance agents' appointments: (A) A filing fee of twenty-five dollars for each request for any agent appointment; (B) a fee of forty dollars for each appointment issued to an agent of a domestic insurance company or for each appointment continued; and (C) a fee of twenty dollars for each appointment issued to an agent of any other insurance company or for each appointment continued, except that no fee shall be payable for an appointment issued to an agent of an insurance company domiciled in a state or foreign country which does not require any fee for an appointment issued to an agent of a Connecticut insurance company; (12) with respect to insurance producers: (A) An examination fee of seven dollars for each examination taken, except when a testing service is used, the testing service shall pay a fee of seven dollars to the commissioner for each examination taken by an applicant; (B) a fee of forty dollars for each license issued; and (C) a fee of forty dollars for each license renewed; (13) with respect to public adjusters: (A) An examination fee of seven dollars for each examination taken, except when a testing service is used, the testing service shall pay a fee of seven dollars to the commissioner for each examination taken by an applicant; and (B) a fee of one hundred twenty-five dollars for each license issued or renewed; (14) with respect to casualty adjusters: (A) An examination fee of ten dollars for each examination taken, except when a testing service is used, the testing service shall pay a fee of ten dollars to the commissioner for each examination taken by an applicant; (B) a fee of forty dollars for each license issued or renewed; and (C) the expense of any examination administered outside the state shall be the responsibility of the entity making the request and such entity shall pay to the commissioner one hundred dollars for such examination and the actual traveling expenses of the examination administrator to administer such examination; (15) with respect to motor vehicle physical damage appraisers: (A) An examination fee of forty dollars

for each examination taken, except when a testing service is used, the testing service shall pay a fee of forty dollars to the commissioner for each examination taken by an applicant; (B) a fee of forty dollars for each license issued or renewed; and (C) the expense of any examination administered outside the state shall be the responsibility of the entity making the request and such entity shall pay to the commissioner one hundred dollars for such examination and the actual traveling expenses of the examination administrator to administer such examination; (16) with respect to certified insurance consultants: (A) An examination fee of thirteen dollars for each examination taken, except when a testing service is used, the testing service shall pay a fee of thirteen dollars to the commissioner for each examination taken by an applicant; (B) a fee of two hundred dollars for each license issued; and (C) a fee of one hundred twenty-five dollars for each license renewed; (17) with respect to surplus lines brokers: (A) An examination fee of ten dollars for each examination taken, except when a testing service is used, the testing service shall pay a fee of ten dollars to the commissioner for each examination taken by an applicant; and (B) a fee of five hundred dollars for each license issued or renewed; (18) with respect to fraternal agents, a fee of forty dollars for each license issued or renewed; (19) a fee of thirteen dollars for each license certificate requested, whether or not a license has been issued; (20) with respect to domestic and foreign benefit societies shall pay: (A) For service of process, twenty-five dollars for each person or insurer to be served; (B) for filing a certified copy of its charter or articles of association, five dollars; (C) for filing the annual report, ten dollars; and (D) for filing any additional paper required by law, three dollars; (21) with respect to foreign benefit societies: (A) For each certificate of organization or compliance, four dollars; (B) for each certified copy of permit, two dollars; and (C) for each copy of a report or certificate of condition of a society to be filed in any other state, four dollars; (22) with respect to reinsurance intermediaries: A fee of five hundred dollars for each license issued or renewed; (23) with respect to viatical settlement providers: (A) A filing fee of thirteen dollars for each initial application for a license made pursuant to section 38a-465a;

and (B) a fee of twenty dollars for each license issued or renewed; (24) with respect to viatical settlement brokers: (A) A filing fee of thirteen dollars for each initial application for a license made pursuant to section 38a-465a; and (B) a fee of twenty dollars for each license issued or renewed; (25) with respect to viatical settlement investment agents: (A) A filing fee of thirteen dollars for each initial application for a license made pursuant to section 38a-465a; and (B) a fee of twenty dollars for each license issued or renewed; (26) with respect to risk-bearing preferred provider networks, a fee of two thousand five hundred dollars for each license issued or renewed; (27) with respect to rental companies, as defined in section 38a-799, a fee of forty dollars for each permit issued or renewed; and (28) with respect to each duplicate license issued a fee of twenty-five dollars for each license issued.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*July 1, 2005*	38a-479aa
Sec. 2	*July 1, 2005*	38a-479bb
Sec. 3	*July 1, 2005*	38a-479cc
Sec. 4	*July 1, 2005*	38a-479dd
Sec. 5	*July 1, 2005*	38a-479ee
Sec. 6	*July 1, 2005*	38a-11(a)

INS *Joint Favorable Subst.*

FIN *Joint Favorable*